Please PRINT Clearly & Use a Pen

City/County: _____

Date: _____

Initial HV Due By: _____

RSVP Client Application

Nevada Rural Counties RSVP Program, Inc.

2621 Northgate Lane, Suite 6, Carson City, NV 89706

Mailing Address: P.O. Box 1708, Carson City, NV

Client Information

Services Requested: Please check all that apply below:

Respite Care: ☐ **Transportation:** ☐ **Companionship/Good Neighbor:** ☐ **PERS:** ☐ **Homemaker:** ☐ **Telephone Reassurance:** ☐

RSVP's volunteers do not perform medical related services, toileting, bathing, administering medications.

VOLUNTEERS ARE STRICTLY PROHIBITED FROM LIFTING OR TRANSFERRING CLIENTS

Legal Name (First/Last): _____ Sex: Male: ☐ Female: ☐

Nickname: _____

Physical Address: _____ ☐ No current address/residence

Mailing Address: _____

City: _____ State: NV Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

E-Mail Address: _____ **Are you a Veteran?** ☐ **Yes** ☐ **No**

DATE OF BIRTH: _____/_____/_____ **Do You Have a Disability?** ☐ **Yes** ☐ **No** ***(If yes, see note on pg 3)***

Marital Status: Married ☐ Single ☐ Do You Consider Yourself Frail? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION ***(If a caregiver is also this client's ER contact, see next page.)***

NAME (First/Last):_____ RELATIONSHIP _____

HOME PHONE: (_____) _____ WORK OR CELL PHONE: (_____) _____

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race:

☐ White, Caucasian ☐ Hispanic ☐ Asian

☐ American Indian/ Alaskan Native

☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander

☐ Other _____

If you do not speak English, what is your primary Language?

_____

Assistive Devices:

☐ Oxygen ☐ Walker

☐ Wheelchair ☐ Cane Other: _____

PLEASE check areas of physical limitation:

☐ Ability to transfer

☐ Ability to stand, grasp, bend, reach, lift

☐ Ability to go outside the home without assistance

☐ Ambulation

☐ Vision

☐ Hearing

Severity of Limitations: ☐ Mild ☐ Moderate ☐ Severe

(Please circle one)

Medical diagnosis of client: _____

Recent hospitalizations and related reasons: _____

Physical impairments and severity of impairments: _____

Mental health conditions:_____

Allergies: _____

Continued Client Information

Which of the following are you UNABLE to perform without assistance?

Activities of Daily Living (ADLs):

- ☐ Eat
- ☐ Walk
- ☐ Get Dressed
- ☐ Use the bathroom
- ☐ Transfer In/or Out of a Bed/Chair
- ☐ Basic hair and oral care

Instrumental Activities of Daily Living (IADLs):

- ☐ Prepare Meals
- ☐ Take Medication
- ☐ Manage Money
- ☐ Shop
- ☐ Light Housework
- ☐ Use Transportation
- ☐ Use Telephone
- ☐ Heavy Housework
- ☐ Driving

Pre-Service Survey (Please answer to the best of your ability)

In general, how would you describe your emotional well being?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

During the past 3 months, how many times have you been able to attend to personal errands such as shopping, banking, etc.?
☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or more

In the past 3 months have you felt isolated?
☐ Often ☐ Sometimes ☐ Never

I often feel stress over my situation
☐ Often ☐ Sometimes ☐ Never

I have received the Notice of Privacy Practices: ☐ Yes ☐ No

Caregiver Information *(Skip if client does not have a caregiver)*

Legal Name (First/Last): _____ Sex: Male: ☐ Female: ☐
Relationship to client: _____ Date of Birth: _____
Physical Address: _____ ☐ No current address/residence
Mailing Address: _____
City: _____ State: NV Zip Code: _____
Phone #: _____ Race/Ethnicity: _____ Age: _____

EMERGENCY CONTACT INFORMATION

NAME (First/Last):_____ RELATIONSHIP _____
HOME PHONE: (_____) _____ WORK OR CELL PHONE: (_____) _____

Pre-Service Survey (Please answer to the best of your ability)

In general, how would you describe your emotional well being?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

During the past 3 months, how many times have you been able to attend to personal errands such as shopping, banking, etc.?
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I often feel stress over my situation
☐ Often ☐ Sometimes ☐ Never

I have received the Notice of Privacy Practices: ☐ Yes ☐ No

Household Information

Home Environment:

Pets: ☐ Yes ☐ No Type: ☐ Dog ☐ Cat ☐ Other: _____

Are the interior/exterior doors, stairs, halls accessible? ☐ Yes ☐ No

Is the kitchen accessible and clear of fire hazards? ☐ Yes ☐ No

Is the refrigerator, oven, heating and plumbing working? ☐ Yes ☐ No

Are the electric outlets and controls accessible and clear? ☐ Yes ☐ No

Are the living and dining areas accessible and clear? ☐ Yes ☐ No

Is a telephone accessible? ☐ Yes ☐ No

Is there a fire extinguisher? ☐ Yes ☐ No Location: _____

Indicate any unsafe conditions: _____

Your Household Income Is: (Please answer ALL!)
☐ BELOW POVERTY ☐ ABOVE POVERTY
Based on 2023 Federal Poverty Guidelines:
1 Person $26,973 ($2,248 per month)
2 People $36,482 ($3,041 per month)
Supplemental Social Security Income Level (SSI):
☐ BELOW 300% SSI ☐ ABOVE 300% SSI
1 Person $ 3,465 per month

Do you live alone? Yes ☐ No ☐ *(circle one)*
Do you receive State Medicaid? Yes ☐ No ☐ *(circle one)*
Female Head of Household? Yes ☐ No ☐ *(circle one)*
Number of persons in household _____
Relationship to the client: _____

Suggested Donation:
Donations are gratefully accepted, however service will not be denied because of inability to contribute.
$10 per trip for local rides
$20 for a round trip ride 50 miles or more
$10 per hour for Respite Care
$10 per hour for Homemaker Services
$10 per shopping and prescription pick-up

How did you hear about RSVP? _____

Referring Agency Contact Name: _____

Phone #: _____ Email: _____

RSVP does not discriminate with regard to race, color or national origin.

Please Note: If you are under the age of 60 and have a disability, you MUST attach your SSDI letter to this applica-tion to qualify for RSVP services.

_____ _____
CLIENT SIGNATURE DATE RSVP REP. SIGNATURE DATE

In order to continue receiving RSVP services, a new client application and Notice of Privacy must be completed each year.

(RSVP STAFF USE ONLY):
Additional Notes:

Aging and Disability Services Division

Confidential Information

Notice of Privacy Practices

The Aging and Disability Services Division (ADSD) must protect your health information by law.

Your health information is personal and private. When you apply for services, you give ADSD information that is used to make you eligible for services. Your health information becomes part of your file. In your file there is information that is given to ADSD by hospitals, doctors and other people who treat you.

This notice explains how ADSD protects your health information and how it may be used and shared. This notice also lets you know how you can get your health information and your rights. Please read carefully.

Your Rights:

You have the right to:

- Ask for your health record or get a copy of your health records. You can look at them in person or get a copy in paper or electronic format. There may be a fee for a copy of your medical records based on policy.
- Ask ADSD for a list of the times that ADSD shared your health information with someone else. This will not include the times we have shared your information for treatment or payment.
- State how you want to be contacted (for example, home or office phone) or to have health information mailed to an address that is different from your usual address.
- Ask ADSD to fix a record if you think something is missing or is wrong in your health record with ADSD.
- Say who can and cannot see your information. Ask ADSD to limit the information shared. ADSD may not always be able to do this.
- Get a list of when and why ADSD shared your information.
- Get a paper copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you think your privacy rights are not protected.

Your Choices:

You have some choices in the way that ADSD uses and shares your health information. For example:

- You can choose for ADSD to share details with family or friends.
- You can choose for ADSD to use your information for special programs.

Notice of Privacy Practices

ADSD may share information during emergencies or when necessary to protect your health and safety if you are unable to do so (such as if you are passed out and cannot talk).

If someone has medical power of attorney or is your legal guardian, that person can exercise your rights and make choices about your health information.

How ADSD Uses Your Information:

ADSD uses your personal information to:

- Provide services and supports.
- Work with doctors, therapists, and caregivers.
- Check the quality of services.
- Help public health officials stop the spread of disease or prevent injury.

When ADSD Shares Your Information:

ADSD will only share your information when:

- You say it is okay.
- A person has authority (medical power of attorney or guardian) and can act for you.
- The law requires ADSD to do so. This may be required by a court or to report abuse and neglect.
- Sharing helps protect your health and safety.
- ADSD is billing for services.

ADSD's Promise to You

- ADSD will never sell your health information.
- ADSD will never use your information for marketing.

ADSD Responsibilities

- ADSD will keep your health information private and safe.
- Give you the Notice of Privacy Practices.
- Follow the law about sharing information.
- Tell you if your personal information is seen, shared, or used by someone who should not have access to it (privacy breach).

Other Privacy Protections

ADSD may use or share your health information with providers on a contract (business associates) to help you get medical care. This includes medical care for things related to pregnancy, birth control, and overall health of the reproductive system.

ADSD has chosen to keep information private and will not share:

- Records related to Substance User Disorder treatment.
- Information about HIV/AIDS or mental health treatment unless allowed by law or with your okay.
- Mental health clinic records. They will only be shared if needed and if it will not cause harm to you or others.
- Protected Health Information to identify someone for any legal action related to reproductive health.

How to File a Complaint

If you think that your privacy rights have not been protected, you can contact ADSD at:

Aging and Disability Services Division, Privacy Officer
1550 E. College Parkway, Carson City, NV 89706
Phone 775-687-4210
Fax 775-687-0574

OR

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

Office for Civil Rights
Dept. of Health and Human Services
907 7th St., Ste. 4-100
San Francisco, CA 94103
Phone 800-368-1019
Fax 415- 437-8329
TDD 800-537-7697
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

ADSD makes sure that no individual is penalized for filing a complaint. ADSD is committed to protecting personal health information and maintaining privacy following all laws.

Aging and Disability Services Division

Confidential Information

Acknowledgement of Receipt Notice of Privacy Practices

(Individual First, Last Name) (Date)

By signing this document, I acknowledge that I have received a copy of the Division Notice of Privacy Practices.

(Individual Signature) (Signature Date)

Division Use Only

Was acknowledgement received? ☐ Yes ☐ No

Reason acknowledgement was not obtained:

(Staff First, Last Name)

(Staff Signature) (Signature Date)

Clear Form